



# Restraint scenarios

**These scenarios are intended to be illustrative only, and should not be relied upon as authority. Providers should be mindful of their obligations under the *Quality of Care Principles 2014*, and pay careful attention to the legislative requirements underpinning the use of restraint when applying those obligations to real-life situations.**

The legal requirements on approved providers about the use of restraint under the *Aged Care Act 1997* are set out in the *Quality of Care Principles 2014* (the Principles) and include obligations on approved providers to ensure that restraint is only used in response to proper clinical assessment and (for chemical restraint) prescribing by health professionals.

Section 15F of the Principles covers use of physical restraint, and section 15G covers chemical restraint.

It is important to note that State and Territory (S and T) laws continue to apply. This is relevant to consent for both physical restraint and chemical restraint. Different States and Territories have differing legislation relating to who can legally give substitute consent and in which specific situations. It is important that prescribers and other health professionals performing a role in relation to restraint are aware of the legislation specific to their own jurisdiction.



## Ronald, 67 year old male

Ronald has a background of chronic schizophrenia, managed by his GP and with regular reviews by his long-standing psychiatrist. His medication is risperidone.

He is happy in the residential aged care service (RACF) and says he enjoys the staff interactions and social opportunities provided. Ronald understands why he is on the medication, and his doctors have assessed that he is able to give his own consent.

### **This IS NOT chemical restraint.**

The medication is to treat a diagnosed mental condition (schizophrenia) and Ronald is consenting.

## Maria, 78 year old female

Maria was diagnosed with dementia four years ago and is taking donepezil (Aricept). She recently transitioned to a secure RACF due to wandering from her home at night, becoming lost and becoming aggressive with family members. Maria was very agitated and upset when she arrived at the RACF, and repeatedly tried to leave. Staff are very vigilant about preventing her from leaving as there is a risk that she will get lost or wander to nearby busy roads and the river.

### **This IS physical (environmental) restraint.**

The locked environment is preventing Maria from going where she wants to. This requires assessment, documentation and consent according to the Principles and the relevant S & T legislation.

Because Maria is distressed and constantly exit-seeking, the RACF staff request the assistance of available behaviour support resources and assistance from the family, to reassure her and give staff strategies to help her settle in. Maria's GP is also asked to help, assesses her and suggests that a low dose of risperidone in the short-term might help with the behaviour and distress. Maria's husband (who is her authorised representative) agrees and gives his informed consent. Maria is calmer. She is monitored for side effects such as drowsiness and there is a clear plan to document her behaviour and to review the need for the risperidone in the following weeks as she settles in.

**This IS chemical restraint.** Although Maria has a diagnosed mental disorder (dementia), risperidone is not a drug to treat dementia. The donepezil she is taking is a drug to treat dementia, the risperidone is not; rather, it is being used to manage associated behaviour. This requires assessment, documentation and consent according to the Principles and the relevant S & T legislation.



## Geoffrey, 92 year old male

Geoffrey has been in the RACF for many years with vascular dementia. He is in a locked secure facility because he was placed in the residential service against his will by a guardian with the appropriate authority, due to extreme risks living at home that he was unable to understand.

When Geoffrey was expressing his wish to leave and had the ability to leave, the locked facility constituted physical restraint.

Geoffrey's health has gradually declined, and his dementia is now advanced. Geoffrey is now bed-bound, doubly incontinent, eating and drinking little and does not talk. He is no longer capable of wishing to leave or trying to leave and is dependent on staff for all care and comfort.

While Geoffrey no longer requires a locked facility, there is no practical alternative, and the RACF considers it would be inhumane and contrary to his best interests to move him given he is approaching the end of his life. He is in a familiar environment with staff who know his individual care needs and preferences, and he is no longer on any medications.

**This is NOT physical restraint.** Geoffrey's overall health status, and not his environment, restricts his free movement. Nothing else is interfering with his freedom of movement. His position would be the same whether or not he is in a locked facility.

Geoffrey's room-mate, **Donald an 88 year old male** with mild dementia, is wheel-chair dependent. He likes to go into the courtyard and sit in the sun and would like to go out of the facility for a change of scenery and to do some shopping. The staff often do not have time to facilitate this.

### **Donald IS being physically restrained**

because his locked environment, as well as his impaired mobility, are interfering with his free movement to do what he wants to do.

## Ann, 84 year old female

Ann has dementia and has lived in the RACF for a few years. She has begun to wander around a lot more and has been getting into other people's beds. She calls out frequently and is awake for many hours at night. The nursing staff ask the GP to provide something to help her sleep. The GP suggests some management strategies and a referral to a behaviour advisory service. The GP prescribes both regular diazepam (Valium) and risperidone PRN (as required) in case she is having a particularly bad night.

**Both of these drugs ARE being used as chemical restraint**, even though in the case of risperidone it is PRN and not regular. Both require assessment, documentation and consent according to the Principles and the relevant S & T legislation.



## Christina, 96 year old female

Christina is deaf and has trouble communicating, however she has no dementia and is not cognitively impaired. She asked her GP for something to help her nausea that is limiting her appetite and her enjoyment of food. She does not want any investigations. The GP outlines the options and the potential side-effects and they decide to try prochlorperazine (Stemetil) and assess for effectiveness and side-effects such as drowsiness.

### **This is NOT chemical restraint.**

The medication is technically categorised as a psychotropic, and it may have side effects such as drowsiness that require monitoring. However it is not being used to influence her behaviour; rather, it is being used as an anti-nausea agent.

## Charles, 68 year old male

Charles is an indigenous man with chronic renal disease, diabetes and he is blind. He does not have any cognitive impairment. He is in a secure RACF which is the only one available near his community and family. He wants to access the community at times and is assisted on outings by staff. At other times he goes out with family members. He cannot see to use the numbered keypad to unlock the door and cannot leave without assistance, but he is able to ask. He does not wish to move to an open (unlocked) RACF that has been offered to him as in his view this will be more restrictive as he will be away from his community, his family will be much less able to take him out, and he will not be on his country. Charles has been assessed by his GP and this is documented appropriately. He has considered alternatives and is able to provide his own informed consent. Additionally, the provider regularly monitors Charles for signs of distress or harm. The provider also reviewed the necessity of the restraint and determined there was no practical alternative.

### **This IS physical (environmental) restraint**

as the provider is restricting Charles' free movement with a locked environment; Charles is not able to leave without assistance. However, the provider is compliant with its responsibilities under the Principles and the relevant S & T legislation.



## Pam, 82 year old female

Pam has dementia and has come into the RACF after a bad fall at home which resulted in a hip fracture that involved a long hospital admission with complications. She is frail, very weak and unsteady, and is meant to be using a frame to walk. Pam forgets about the frame and whenever she wants to go to the bathroom she gets up impulsively and tries to rush unaided. She has had two near-miss falls in the facility. The staff decide to put her in a recliner chair to prevent her walking unaided and falling. The chair is very comfortable, but she is unable to get out of it without assistance.

**This IS physical restraint** as Pam is being prevented from moving freely, even though the motivation is safety. It requires assessment, documentation and consent according to the Principles and the relevant S & T legislation.

When Pam was noted to be incontinent in the recliner, the staff put in a regime of regular toileting which was successful in eliminating incontinence and also stopped the impulsive rushing behaviour.

## George, 79 year old male

George is normally able to come and go freely from his RACF using the numbers on the keypad at the door. One day he is very confused, incontinent and behaving inappropriately, abusing other residents and refusing to eat, get out of his wet clothes or to shower.

Staff consider the options of: securing him in a chair with a lap-sash; or calling the GP for a phone order of risperidone to settle him down and to prevent him from harming himself or others.

**BOTH of these options ARE restraint.**

However the staff realise that a sudden change in behaviour like this represents a clinical deterioration and there may be a serious underlying medical condition causing it. George may have a delirium and the cause needs to be investigated. The decision is made to transfer him to hospital and his family are notified. George developed pneumonia, is successfully treated and returns to the facility. George is back to his old self and does not require any restraint measures.



## Ken, 74 year old male

Ken has dementia which was diagnosed three years ago. He has increasingly shown disinhibition and sexualised behaviours. He makes frequent inappropriate sexual remarks to the female staff and is exposing himself to female visitors. The staff ask for medication to be prescribed for Ken to reduce the offending behaviours. The GP prescribes cyproterone (Androcur) as an anti-androgen medication to reduce testosterone and sexual desire.

When Ken's family find out a few months later they are upset with this approach and wish to know why Ken's rights have not been respected and why they have not been consulted. The Nurse Manager speaks to the family about the medication and the rationale. It is explained that the GP has the role of obtaining informed consent, but the facility will not administer medication if they are aware that consent has not been legally obtained, especially when the resident and their family are objecting. The family and Ken all refuse to give consent and are mindful of Ken's ability to experience pleasure and the potential serious side effects of the drug.

A meeting is set up with the GP. Prior to the meeting the GP becomes aware that Androcur administration is considered chemical restraint. The GP apologises to Ken and an agreement is reached to engage a behaviour support specialist and to provide Ken with privacy when required. Medication is stopped and his behaviour is monitored and documented.

**Anti-androgen medication to affect behaviour IS chemical restraint.** It requires assessment, documentation and consent according to the Principles and the relevant S & T legislation.

## Merle, 79 year old female

Merle is in a secure (locked) facility. She has very poor vision and hearing, and does not want to go out alone and unassisted. She is very concerned about her bed mobility as she has recently fallen out of bed while trying to get up. She is frightened to roll over in bed in case she is too close to the edge. She would like to have the bed rails up at night to prevent her falling out and give her confidence to move in bed. She also finds rails help her move in the bed by giving her something to grab on to. If she wants the rails down she is able to use the call buzzer. The care worker is concerned that the use of bed rails represents physical restraint. The provider regularly monitors Merle for signs of distress or harm. It also reviewed the necessity of the restraint in the context of Merle's wishes, and determined that there was no practical alternative.

**The secure facility and the use of bed rails are BOTH physical restraint,** as they are restricting Merle's free movement. However if assessment, documentation and consent according to the Principles and the relevant S & T legislation have been obtained then the provider is compliant with their responsibilities.



## Wally, 88 year old male

Wally has dementia and has started to get up by himself and try to get to the bathroom at night. He has recently commenced on risperidone at night to try to prevent him waking and becoming agitated. Since administering this medication, the care staff have observed him staggering in the wrong direction, looking very unsteady and confused. They wonder if putting the bed rails up will prevent Wally from getting up and putting himself at risk. On the first night that the bed rails are used, Wally is found with his leg caught, very distressed, trying to get over the rail.

Now very concerned, the facility staff reassess the situation and realise that the risperidone has made Wally more unsafe at night, as he is more drowsy, confused and unsteady. The rails also have increased the risk of harm from falling while trying to climb over them.

**The staff realise that this management IS restraint**, both chemical and physical, and it is not working well for Wally. They cease both measures immediately. They look for causes of Wally's night time agitation and find that he is having difficulty emptying his bladder. This is raised with Wally's GP and the staff also provide regular assisted toilet opportunities through the night with a bottle. They move Wally's bed so that staff can see him easily if he wants to get up.

## Marion, 66 year old female

Marion has a lifelong intellectual disability and has begun to demonstrate some behaviours of concern. She constantly picks and scratches at her skin and at times makes herself bleed. Her torso has scars, abrasions and shallow ulcers which bleed as she picks at them.

The care staff dress Marion in an 'all-in-one' leotard-type underwear, overalls and outer clothes which zip at the back. Marion can no longer reach areas of her body, and her self-injuring improves. She cannot toilet herself anymore and needs either pads or assistance to toilet. She often tries to toilet herself and is distressed because she cannot undress herself.

**This IS restraint** (physical) as clothing is used to restrict Marion's free movement (access to her own skin and toileting), even if the movement (scratching etc.) is doing her harm. It requires assessment, documentation and consent according to the Principles and the relevant S & T legislation.

As the scratching is new, medical attention is sought. Marion is diagnosed with atypical scabies, the correct treatment rapidly resolves the skin problem, and the restrictive practice (restraint) is no longer used.



## Evan, 74 year old male

Evan has severe osteoarthritis and mild dementia. He is normally quiet and likes to sit in the sun and smoke. He has had a long-term habit of drinking beer and whiskey in the evening. He reluctantly moves into a RACF as he can no longer manage living alone.

On the day after he arrives, Evan is angry, shouting and confused. He has a tremor. He is convinced that someone has stolen his wallet and believes he is in his own home with intruders. He demands some alcohol. The GP assesses Evan and recognises that his acute (sudden) confused state is likely due to alcohol withdrawal and prescribes diazepam (Valium) with the intention of gradually reducing the dose, or transferring Evan to hospital if he doesn't settle easily.

Evan does well, and in two weeks is no longer on any Valium. He has settled in to the facility and enjoys the company. He has negotiated access to alcohol with dinner with the facility manager.

**This IS NOT chemical restraint**, as diazepam is a recognised treatment for alcohol withdrawal.

## Hazel, 84 year old female

Hazel has disabling Parkinson's Disease. When she moves in to the RACF, she calls out at night for attention and when staff arrive she doesn't seem to have anything wrong. Some of the other residents are complaining about the noise. Hazel sleeps a lot during the day and is not wanting to wake for meals. She is losing weight. The staff request that the GP prescribe risperidone at night for Hazel. The GP does not want to use this chemical restraint without exploring other measures, and also recognises that it is medically complex as antipsychotics such as risperidone are relatively contraindicated with Parkinson's Disease. The GP refers Hazel to a geriatrician for specialist assessment.

Hazel's family are consulted and tell the staff that Hazel loves TV and gets frightened when alone. The TV is left on overnight when she is awake, and her bed is moved so she can see staff. Hazel's dinner is kept in the fridge then re-heated and given to her when she is awake, and she is given other snacks overnight to compensate for her missing some meals during the day.





## Viv, 86 year old female

Viv is admitted to the RACF from hospital. She has moderate dementia but is cheerful and settled. She has never had any behaviours of concern. Viv's daughters ask to check the medications she is being given to be sure they are correct. They notice that she is prescribed risperidone PRN (to be given when necessary). This is not something Viv normally takes, and they question it. They are told that it is routine for residents to be prescribed this by their GPs 'just in case'. They look up the uses and side effects. They are concerned as they do not think it will be needed and do not want Viv to have it. They have a meeting to express their concerns. They have not given consent for this and understand that informed consent is required even for PRN medications. The care manager confirms that this is the case and reassures the family that the residential care staff will work with the GP to ensure that risperidone will not be given unless there has been clear assessment, communication, discussion and consent.

The manager identifies that there may be other residents in this position, and realises that routine prescribing of psychotropic medication for consumers 'just in case' is unsatisfactory. The manager arranges a review of the other residents' medications, and also of the service's processes, to ensure the practice is discontinued in this form.

### **This prescribing of risperidone, including in a PRN setting, IS chemical restraint.**

At the time PRN medication is prescribed, a consumer must be assessed by the prescriber as requiring chemical restraint from time to time in the foreseeable future in clearly specified circumstances. It is not acceptable to have a prescription made out 'just in case' it is needed. It requires assessment, documentation and consent according to the Principles and the relevant S & T legislation.



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